

Provider Insider

Alabama Medicaid Bulletin

July 2005

The checkwrite schedule is as follows:

7/08/05 7/22/05 8/05/05 8/19/05 9/02/05 9/09/05

As always, the release of direct deposits and checks depends on the availability of funds.

Alabama Medicaid Adopts ASP Methodology

Effective for Dates of Service July 1, 2005 and thereafter, the Alabama Medicaid Agency will adopt Medicare's Drug Pricing Methodology using the Average Sale Price (ASP) for HCPCS injectable drug codes. In keeping with Medicare guidelines, Alabama Medicaid will also adopt the temporary G codes designated for Chemotherapy and Non-Chemotherapy administration codes. These codes are effective for services provided on or after July 1, 2005 and before January 1, 2006. The crosswalk between the previous codes and the new codes is outlined on page 2 of this Alert. The following CPT drug administration codes will remain in effect and covered for 2005.

- CPT codes 90783 and 90788,
- CPT codes 96405 to 96406,
- CPT codes 96420 to 96520,
- CPT codes 96530 to 96549.

The change to the G codes brings about an improvement in billing and reporting codes through the creation of new codes to identify initial infusions and additional sequential infusions.

There are also new codes to identify additional

non-chemotherapy sequential intravenous pushes and intravenous chemotherapy pushes for additional drugs.

Alabama Medicaid has established the following new guidelines that should be utilized by physicians when billing for administration codes.

- For non-chemotherapy injections, services described by codes G0351, G0353, G0354, and CPT codes 90783 and 90788, may be billed in addition to other physician fee schedule services billed by the same provider on the same day of service.
- For IV infusions and chemotherapy infusions, if a significant separately identifiable E & M service is performed, the appropriate E & M CPT code should be reported utilizing modifier 25.

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Pass It On!

Everyone needs to know
the latest about Medicaid.
Be sure to route this to:

- ☐ Office Manager
- ☐ Billing Dept.
- ☐ Medical/Clinical Professionals
- ☐ Other _____

Notifying Medicaid of Insurance Changes

When notifying Medicaid of a change in a recipient's health insurance, you may use the following format:

_____ Change in Insurance _____ Reporting Insurance Unknown to State

Recipient's Name: _____

Medicaid #: _____

Other Medicaid recipients in household with same insurance coverage:

Name: _____ Medicaid # _____

Name: _____ Medicaid # _____

Name: _____ Medicaid # _____

Name: _____ Medicaid # _____

Name of Insurance Company: _____

Address: _____

Name of Insured
(Subscriber or Policyholder): _____

Policy Number: _____ Group # _____

Group Name: _____

Effective Date: _____

Termination Date: _____

Changes in coverage: _____

Sender's Name: _____

Provider's Name: _____

Telephone Number: _____

This information may be faxed to 334-353-5375.

You may also phone in this information to the following individuals:

If the patient's last name begins with:

A – G Call 334-242-5280

H – P Call 334-242-5254

Q – Z Call 334-242-5279

More Drugs Added to the Electronic Prior Authorization System

Effective May 26, 2005, the Alabama Medicaid Agency implemented another phase of drugs to the electronic prior authorization (PA) system. The drug classes included in this implementation phase are as follows:

Cardiac Agents
Antihypertensive Agents
Anxiolytic/Sedative/Hypnotic Agents

There will be no change in the way a pharmacist submits a claim. Medicaid's system will check claims history to determine if PA medical requirements are met. If it is determined that all criteria are met and request is approved, the claim will pay and no manual PA request will be required. If approval cannot be determined based on available claims history, a manual PA request will be needed. Here is how it works:

Example A:

A pharmacist submits a claim for a cardiac agent. The patient has tried and failed on two prior therapies that were billed and paid by Medicaid and has had a medical claim filed with an appropriate diagnosis. The system will identify these claims and match them with the clinical criteria. If all criteria are met as in this example, the claim will pay automatically and no manual PA will need to be obtained.

Example B:

A pharmacist submits a claim for an anxiolytic/sedative/hypnotic agent. The patient has tried and failed on two prior therapies that were billed and paid by Medicaid but has quantity over the maximum unit allowed for the drug. The system will send an "On-Line PA Denied" message to the pharmacist. The pharmacy/physician must then initiate a manual PA request. An online PA denial does not mean that the service requested is considered a non-covered service; only non-covered services can be charged to the recipient. To determine if a service that has received an online PA denial is covered, a manual PA request must be completed. Only after the manual PA request is denied, can the pharmacist charge the recipient.

Some possible reasons for an electronic denial:

1. Patient does not meet clinical criteria based on available claims history
2. Units dispensed are over 100% of the maximum quantity limits
3. Previous PA issued and still in effect with a different NDC
4. Recipient is a new Medicaid eligible and no claims history exists

Please direct policy questions to the Alabama Medicaid office at (334) 242-5050. All questions concerning prior authorization denials/approvals should be directed to Health Information Designs, Inc. at (800) 748-0130.



REMINDER **Outpatient Fee Schedule**



Providers should refer to the fee schedule before scheduling outpatient surgeries since some procedures are restricted to recipients under age 20 and others may require prior authorization. The fee schedule is updated each quarter and may be found on the website: www.medicaid.state.al.us

Minimum Requirements for Microsoft Have Changed

With the addition of new operating systems, Microsoft has decided to no longer support Windows 95, 98, 98 second addition, NT and ME. Any problems encountered with Windows 98, NT or ME are currently supported by Microsoft if the user is willing to pay for such services. This paid incident support is valid with Microsoft until June 30, 2006. Therefore, EDS will now be increasing their minimum requirements to Windows 2000 on all Medicaid software and manuals which includes: Provider Electronic Solutions, LTC Admission Notification and the Alabama Medicaid Provider Manual. If you have any questions, contact the EMC Helpdesk at 800-456-1242.

Use of Modifier 59 on Physician and Outpatient Claims

Under certain circumstances, the physician may need to indicate that a procedure or service was distinct or independent from other services performed on the same day. Modifier 59 is used to identify procedures/services that are not normally reported together, but are appropriate under the circumstances. This may represent a different session or patient encounter, different procedure or surgery, different site or organ system, separate incision/excision, separate lesion, or separate injury, not ordinarily encountered or performed on the same day by the same physician. However, when another already established modifier is appropriate it should be used rather than modifier 59. Only if no more descriptive modifier is available, and the use of modifier 59 best explains the circumstances, should modifier 59 be used.



www.medicaid.state.al.us

Issues Involving Access to InfoSolutions

The Agency has identified problems encountered by some providers while accessing pharmacy information on InfoSolutions. Due to these problems the Agency has extended the utilization deadline for InfoSolutions for 60 days while these issues are being resolved. Therefore, effective August 1, 2005, the Agency will discontinue paying additional case management monies if reports show providers who signed up for this case management fee are not actively utilizing InfoSolutions.

If you have questions regarding InfoSolutions please contact the InfoSolutions department at (205) 220-5900, Paige Clark at (334) 242-5148, or Gloria Wright at (334) 353-5907.

Attention Hospitals

Medicaid uses Correct Coding Initiative (CCI) edits as one of several audit tools during post-payment reviews. A hospital's use of CCI or any other coding software is the provider's option.

Billing Information for Hospitals and Independent Labs

Lab codes (80000-89356) and venipuncture (36415-90) or capillary stick (36416-90) should not be billed on the same day by the same provider. In such instances the collection code will be denied and the lab code paid.

Billing Information for Community Mental Health Centers

Use H2021 to bill In-Home Intervention services rendered to adults age 19+ for dates of service beginning June 1, 2005. Use H2021 to bill for services rendered to children ONLY for dates of service PRIOR to June 1, 2005. For dates of service beginning June 1, 2005 you MUST use H2021-HA to bill In-Home Intervention services rendered to children age <18.

Hospice Medical Necessity Criteria

Effective June 16, 2005, all Hospice Providers are required to use criteria specific to the Medicaid program to determine medical necessity for recipients electing the hospice benefit when Medicaid is the primary payor. Providers should no longer use the Palmetto GBA Medicare Local Medical Review Policy (LMRP) to determine medical necessity for the hospice program when Medicaid is the primary payor for the hospice services. Chapter 51 of the Alabama Agency Administrative Code, Rule No. 560-X-51-.04 contains the new criteria. The Medicaid hospice criteria are also available on the Alabama Medicaid Agency Website at www.medicaid.state.al.us.

Coverage For Pegaptamib Sodium

Approval was received to add the drug Pegaptamib Sodium (Macugen) .3 MG to the list of codes that may be billed with procedure code J3490 (Unclassified Drug). When billing for Unclassified Drugs, clean claims should be submitted to EDS by hard copy indicating the J3490 procedure code and NDC number. Unclassified Drugs will be removed from the approved list when a specific HCPCS code is established.

Updated Vaccine for Children Codes

The VFC Program has added a new code (90714) effective July 1, 2005. The current list of available VFC codes with effective dates is listed below for your information and convenience. Please share this information with your billing staff. For more information, please refer to Appendix A of the provider manual.

CPT-4 Procedure Code Immunization

90645	Haemophilus influenzae type b (Hib) titer
90647	Haemophilus influenzae type b (Pedvax)
90648	Haemophilus influenzae type b (ActHib)
90655	Influenza, preservative-free (6-35 months) – Eff. 1-1-05
90656	Haemophilus influenzae, split virus, preservative free (3 years and older) – Eff 1-1-05
90657	Influenza (6-35 months)
90669	Pneumococcal Conjugate vaccine 7 valent (Pnu 7)
90700	Diphtheria, Tetanus, Acellular Pertussis (DtaP)
90702	Diphtheria, Tetanus (DT)
90707	Measles, Mumps, Rubella (MMR))
90713	Poliomyelitis (IPV)
90714	Tetanus, Diphtheria (Td), preservative-free – Eff. 7-1-05
90715	Tetanus Toxoid, Reduced Diphtheria Toxoid and Acellular Pertussis Vaccine, Adsorbed (Tdap) – Eff. 5-3-05
90716	Varicella (Chicken pox) vaccine (for selected recipients)
90718	Tetanus and Diphtheria (Td) (for adult use)
90721	Diphtheria, Tetanus, Acellular Pertussis and Hemophilus influenzae b (DTaP-HIB)
90723	Pediarix (DtaP-Hep B-IPV)
90732	Pneumococcal polysaccharide virus 23 valent (Pnu 23)
90733	Meningococcal Polysaccharide (MPSV4), (2-18 yr of age) – Eff. 2-10-05
90734	Meningococcal Conjugate (MCV4), (11-18 yr of age) – Eff 3-1-05
90744	Hepatitis B vaccine (Hep B)
90748	Hepatitis B and Hemophilus influenzae b (Hep B-Hib)

New Procedure Codes For Intravenous Immune Globulin

Effective for dates of service on or after July 1, 2005, procedure codes J1563 Immune Globulin, Intravenous, 1 G and J1564 Immune Globulin, Intravenous, 10 MG will no longer be covered by Alabama Medicaid. Codes J1563 and J1564 will be replaced with HCPC codes Q9941 – Q9944. The following chart defines the descriptions of the new Q codes.

HCPCS Code	Short Descriptor	Long Descriptor
Q9941	IVIG lyophil 1G	Injection, Immune Globulin, Intravenous Lyophilized, 1 G
Q9942	IVIG lyophil 10 MG	Injection, Immune Globulin, Intravenous Lyophilized, 10 MG
Q9943	IVIG non-lyophil 1 G	Injection, Immune Globulin, Intravenous Non-Lyophilized, 1 G
Q9944	IVIG non-lyophil 10 MG	Injection, Immune Globulin, Intravenous Non-Lyophilized, 10 MG

Providers must bill Q9941 or Q9943, as appropriate, in place of J1563. Similarly, providers must bill Q9942 or Q9944, as appropriate, instead of J1564.

Erectile Dysfunction Drugs

Effective June 8, 2005, the Alabama Medicaid Agency will no longer approve Erectile Dysfunction drugs for impotence. These drugs will be approved for patients who have severe pulmonary hypertension. Criteria for these drugs are as follows:

- Phosphodiesterase inhibitors require diagnosis of severe pulmonary hypertension (defined as systolic pulmonary pressure > 80mm HG as determined by cardiac catheterization) with documentation of failure of or contraindication to all other available therapies. Documentation must be provided of vasoreactivity testing and consultation with a specialist experienced in the treatment of pulmonary hypertension patients.
- A sole diagnosis of impotence will not be approved.

Providers with questions concerning the new Erectile Dysfunction criteria may contact:

Health Information Designs (HID)
Medicaid Pharmacy Administrative Services
P. O. Box 3210
Auburn, AL 36832-3210

Please visit the website www.medicaid.state.al.us for more information and the latest Medicaid news.

New ADA Dental Claim Form Now Accepted

Beginning in June, dental providers may begin using the ADA Version 2002,2004 Dental Claim form. This claim form has been published by the American Dental Association as the standard claim form in the CDT-4 and CDT2005. To be consistent with the ADA's publication, Medicaid will be transitioning to this claim form. Minor changes with this claim form include: Prior Authorization numbers will be entered into block 2, Oral Cavity Designation code block 25, other insurance paid in block 32, "TPL Denial Attached" should be entered in block 35, performing provider number once in block 49, group number in block 50 and TAX ID/SSN in block 51. The Dental Program will be providing additional education on this claim form. This article is to alert those dental providers who are familiar with this form it is now being accepted. If you have questions, please call Tina Edwards at 334-242-5472.

Injectable Drug Units

When billing for injectable drugs, Providers should note the description of the HCPCS code utilized. The description or dose indicated in the HCPCS description represents 1 (one) billing unit. An example is the code J2505 Pegfilgrastim (Neulasta) 6 mg. The standard dosage for Pegfilgrastim is 6 mg per dose and therefore should be billed as 1 (one) billing unit.

Maximum units are established for injectable medications based on recommended dosages. Billing in excess of recommended dosages are subject to post payment review and/or adjustments.

Important Mailing Addresses

All Claim forms, Consent forms, and other mail	EDS Post Office Box 244032 Montgomery, AL 36124-4032
Inquiries, Provider Enrollment Information, and Provider Relations	EDS Post Office Box 241685 Montgomery, AL 36124-1685
Adjustments	EDS Post Office Box 241684 Montgomery, AL 36124-1684

DME Tidbits

A written order or a signed prescription from the attending physician to a participating supplier determines medical necessity for covered items of supplies and appliances. A prescription for DME (durable medical equipment) items requiring prior authorization is considered to be outdated by Medicaid when it is presented to EDS past ninety days from the date it was written. A prescription for DME items and supplies not requiring prior authorization is considered outdated by Medicaid when it is presented to the provider past ninety days from the date it was written.

Effective June 1, 2005 Phototherapy will no longer be covered using procedure code S9120. Procedure code S9120 will be replaced with procedure code E0202.

Effective immediately an EPSDT Screening is not required for Phototherapy. This policy change is retroactive for all Phototherapy claims with dates of service from March 1, 2004.

The Motorized/Power Wheelchair Assessment Form, Form 384, can be completed by any licensed OT/PT. However, reimbursement is not available for OTs performing this evaluation for adults or for PTs not associated with a hospital. The OT/PT performing the assessment may not be affiliated in any way with the DME Company requesting the evaluation. If any of the parties are affiliated all parties, the OT/PT and DME Company, will be penalized and referred to the Medicaid Fraud and Investigation Unit. If you have additional questions or need further clarification, please contact LTC Provider / Recipient Services at 1-800-362-1504.

Attention Surgeons

Surgeons are responsible for submitting hard copy hysterectomy and tubal ligation consent forms to EDS at P. O. Box 244032, Montgomery, AL 36124 Attn: Desiree Nelson. Hysterectomy and tubal ligation consent forms are scanned and matched electronically with the related claims before processing. It is imperative consent forms are submitted timely to allow all providers (e.g., surgeons, anesthesiologists, hospitals, etc.) reimbursement. Claims submitted prior to consent forms are denied. Multiple complaints have been received. Thank you for your assistance with this important request.

Alabama's Listening

The following information was shared at the December 14, 2004 Universal Newborn Hearing Screening Advisory Board Meeting.

- All of the 59 birthing hospitals are performing universal newborn hearing screenings
- 97% of newborns are screened
- The referral rate is 5%
- There are three hearing screening machines available for loan through the Alabama Department of Public Health
- The Alabama Department of Public Health has awarded CEUs for nurses who successfully complete training to perform universal newborn hearing screenings
- Alabama Medicaid Agency's EPSDT Care Coordination services are invaluable for the universal newborn hearing screenings program
- 78% of participants are followed up for re-testing

The Universal Newborn Hearing Screening Program requests the assistance of audiologists, pediatricians, family practice physicians, and otolaryngologists in reporting all hearing screening tests to the Alabama Department of Public Health. The telephone number is 334-206-2944 and the email address is melissatucker@adph.state.al.us.

Alabama Medicaid Adopts ASP Methodology

(Continued from page 1)

- When administering multiple infusions, injections, or combinations, only one "initial" drug administration service code should be reported per patient per day, unless protocol requires that two separate IV sites must be utilized. The initial code is the code that best describes the service the patient is receiving and the additional codes are secondary to the initial code.
- "Subsequent" drug administration codes, or codes that state the code is listed separately in addition to the code for the primary procedure, should be used to report these secondary codes. If an injection or infusion is of a subsequent or concurrent nature, even if it is the first such service within that group of services, then a subsequent or concurrent code from the appropriate section should be reported.
- If the patient has to come back for a separately identifiable service on the same day, or has 2 IV lines per protocol these services are considered separately billable with a modifier 76.
- The Procedure Code Crosswalk table can be found on page 8 of this Provider Insider.

If you need additional clarification or information, please contact Mary Timmerman, Associate Director, Medical Support Programs by e-mail at mtimmerman@medicaid.state.al.us or by phone at (334) 242-5014. Chapter 28 of the Alabama Medicaid Provider Manual will also be updated.

New Prior Authorization Form for Dental Providers

Effectively immediately, dental providers may begin using the revised Dental Prior Authorization form. The changes are based on your comments and make it easier for providers to complete. If you have questions, on how to obtain copies, please call Tina Edwards at 334-242-5472 or log-on to our website at www.medicaid.state.al.us.

ALABAMA PRIOR REVIEW AND AUTHORIZATION DENTAL REQUEST

<p>Section I – Must be completed by a Medicaid provider.</p> <p>Requesting Provider License No. _____</p> <p>Phone() _____</p> <p>Name _____</p> <p>Address _____</p> <p>City/State/Zip _____</p> <p>Provider Medicaid Number _____</p> <p style="text-align: center;">(9-digit provider number is required.)</p>	<p>Section II</p> <p>Medicaid Recipient Identification Number _____</p> <p style="text-align: center;">(13-digit RID number is required.)</p> <p>Name as shown in Medicaid system _____</p> <p>Address _____</p> <p>City/State/Zip _____</p> <p>Telephone Number _____</p>
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[illegible]

Section IV

1. Indicate on the diagram below the tooth/teeth to be treated.

1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17

2. Detailed description of condition or reason for the treatment:

3. Brief Dental/Medical History: _____

When x-rays or photos are required per criteria, please send them in a separate, sealed envelope marked "Confidential." Make sure the recipient's name and Medicaid number are included with the X-rays or photos.

Certification Statement: This is to certify the requested service, equipment, or supply is medically indicated and is reasonable and necessary for the treatment of this patient. This Form and any statement on my letterhead attached hereto have been completed by me, or by my employee and reviewed by me. The foregoing information is true, accurate, and complete, and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.

Signature of Requesting Dentist _____ Date of Submission _____

FORWARD TO: EDS, P.O. Box 244032, Montgomery, Alabama 36124-4032
Form 343 05/05

Alabama Medicaid Agency

Alabama Medicaid Adopts ASP Methodology - Procedure Code Crosswalk

(Continued from page 6)

Old Code	New Code	Descriptor	Add-On Code
90780	G0345	Intravenous infusion, hydration; initial, up to 1 hour	
90781	G0346	Intravenous infusion, hydration; each additional hour, up to 8 hours (List separately in addition to code for procedure)	Yes
90780	G0347	Intravenous infusion, for therapy/diagnosis; initial, up to 1 hour (Specify substance or drug)	
90781	G0348	Intravenous infusion, for therapy/diagnosis (Specify substance or drug); Each additional hour, up to 8 hours (List separately in addition to code for procedure)	Yes
90781	G0349	Intravenous infusion, for therapy/diagnosis (Specify substance or drug); Additional sequential infusion, up to 1 hour (List separately in addition to code for procedure)	Yes
NA	G0350	Intravenous infusion, for therapy/diagnosis (Specify substance or drug); Concurrent infusion (List separately in addition to code for procedure)	Yes
90782	G0351	Therapeutic or diagnostic injection (Specify substance or drug); Subcutaneous or Intramuscular	
90784	G0353	Therapeutic or diagnostic injection (Specify substance or drug); Intravenous push, single or initial substance/drug	
NA	G0354	Therapeutic or diagnostic injection (Specify substance or drug); Each additional sequential intravenous push (List separately in addition to code for primary procedure)	Yes
96400	G0355	Chemotherapy administration, subcutaneous or intramuscular; Non-hormonal antineoplastic	
96400	G0356	Chemotherapy administration, subcutaneous or intramuscular; hormonal antineoplastic	
96408	G0357	Chemotherapy administration, intravenous; push technique, Single of initial substance/drug	
96408	G0358	Chemotherapy administration, intravenous; push technique, Each additional substance/drug (List separately in addition to code for primary procedure)	Yes
96410	G0359	Chemotherapy administration, intravenous infusion technique; Up to 1 hour, single or initial substance/drug	
96412	G0360	Chemotherapy administration, intravenous infusion technique, Each additional hour, 1 to 8 hours (List separately in addition to code for primary procedure)	Yes
96414	G0361	Chemotherapy administration, intravenous initiation of prolonged Chemotherapy infusion (more than 8 hours), requiring use of a Portable or implantable pump	
96412	G0362	Chemotherapy administration, intravenous infusion technique; Each additional sequential infusion, (different substance/drug) Up to 1 hour (List separately in addition to code for primary procedure)	Yes
NA	G0363	Irrigation of implanted venous access device for drug delivery system Reimbursable only when performed as a single service	

Montgomery, AL 36124-4032
Post Office Box 244032

**Alabama
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